U.S. Department of Labor

Office of Administrative Law Judges
Seven Parkway Center - Room 290
Pittsburgh, PA 15220

(412) 644-5754
(412) 644-5005 (FAX)

Issue Date: 01 March 2005

CASE NO.: 2003-BLA-6642

In the Matter of

RICHARD L. OWSLEY,
Claimant

v.

APOGEE COAL CO./
ARCH OF WEST VIRGINIA,
Employer

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,
Party-in-Interest

Appearances:

S.F. Raymond Smith, Esq.,
For the Claimant

Mary Rich Maloy, Esq.,
For the Employer

Before: RICHARD A. MORGAN
Administrative Law Judge

DECISION AND ORDER DENYING BENEFITS

This proceeding arises from a miner's claim for benefits, under the Black Lung Benefits Act, 30 U.S.C. § 901 *et seq*., as amended ("Act"), filed on July 16, 2002, respectively. The Act and implementing regulations, 20 C.F.R. parts 410, 718, and 727 (Regulations), provide compensation and other benefits to:

1. Living coal miners who are totally disabled due to pneumoconiosis and their dependents;
2. Surviving dependents of coal miners whose death was due to pneumoconiosis; and,

3. Surviving dependents of coal miners who were totally disabled due to pneumoconiosis at the time of their death.

The Act and Regulations define pneumoconiosis ("black lung disease" or "coal worker's pneumoconiosis" ("CWP") as a chronic dust disease of the lungs and its sequelae, including respiratory and pulmonary impairments arising out of coal mine employment.

PROCEDURAL HISTORY

The claimant filed his claim for benefits on July 16, 2002. (Director's Exhibit 1 ("DX")). The claim was approved by the district director because the evidence established the elements of entitlement that Mr. Owsley has coal workers' pneumoconiosis and is totally disabled due to pneumoconiosis. (DX 24). On, July 2, 2003 and again on July 16, 2003, the employer requested a hearing before an administrative law judge. (DX 26 & 29). On September 18, 2003, the case was referred to the Office of Administrative Law Judges by the Director, Office of Workers' Compensation Program (OWCP) for a formal hearing. (DX 31). I was assigned the case on May 20, 2004.

On October 28, 2004, I held a hearing in Charleston, West Virginia, at which the claimant and employer were represented by counsel.[1] No appearance was entered for the Director, Office of Workman Compensation Programs (OWCP). The parties were afforded the full opportunity to present evidence and argument. Claimant's exhibits ("CX") 1 and 2, Director's exhibits ("DX") 1- 33, and Employer's exhibits ("EX") 1-3, (not EX 2A), 5-8, 13, 15 and 16 were admitted into the record.

ISSUES

I. Whether the miner has pneumoconiosis as defined by the Act and the Regulations?

II. Whether the miner's pneumoconiosis arose out of his coal mine employment?

III. Whether the miner is totally disabled?

IV. Whether the miner's total disability is due to pneumoconiosis?

V. The number of dependents for the purpose of augmentation of benefits.

[1] Under *Shupe v. Director, OWCP*, 12 B.L.R. 1-200, 1-202 (1998)(en banc), the location of a miner's last coal mine employment, i.e., here the state in which the hearing was held, is determinative of the circuit court's jurisdiction. Under *Kopp v. Director, OWCP*, 877 F.2d 307, 309 (4th Cir. 1989), the area the miner was exposed to coal dust, i.e., here the state in which the hearing was held, is determinative of the circuit court's jurisdiction.

FINDINGS OF FACT

I. Background

A. Coal Miner

The claimant was a coal miner, within the meaning of § 402(d) of the Act and § 725.202 of the Regulations, for at least 17 years. (Hearing Transcript (TR) 9-11).

B. Date of Filing

The claimant filed his claim for benefits, under the Act, on July 16, 2002. (DX 1). None of the Act's filing time limitations are applicable; thus, the claim was timely filed.

C. Responsible Operator

Apogee Coal Company is the last employer for whom the claimant worked a cumulative period of at least one year and is the properly designated responsible coal mine operator in this case, under Subpart F (Subpart G for claims filed on or after Jan. 19, 2001), Part 725 of the Regulations. (TR 9).

D. Dependents

The claimant has two dependents for purposes of augmentation of benefits under the Act, his wife, Pamela Ann and his son, Tyler Clark. (DX 7, 8; TR 12).

E. Personal, Employment and Smoking History[2]

The claimant was born on November 21, 1949. (DX 1). He married Pamela Ann Clark, on December 3, 1977. (DX 7) . The claimant's last position in the coal mines was that of a rock truck driver. (DX 1; TR 9).

The claimant, as part of his duties, was required to climb a ladder twenty-three feet to enter the cab of his truck, and drive the truck on a strip mine site. (DX 1; TR 9).

There is evidence of record that the claimant's respiratory disability is due, in part, to his history of cigarette smoking. The evidence is conflicting concerning the miner's smoking history. However, I find he smoked one pack per day for thirty-five years. All of the smoking histories note that the claimant began smoking cigarettes in 1967 at a rate of one pack per day. (TR 13; DX 10; EX 3 & 7). Additionally, all of the histories noted indicate that the claimant was smoking approximately eight to ten cigarettes per day at the time of the examination or hearing. (TR 13; DX 10; EX 3 & 7). Based on the foregoing, I have found that the claimant's smoking history constitutes a thirty-five pack year history. This finding takes into account the fact that

[2] "The BLBA, judicial precedent, and the program regulations do not permit an award based solely upon smoking-induced disability." 65 Fed. Reg. 79948, No. 245 (Dec. 20, 2000).

the claimant has reduced his smoking habit in recent years to approximately one-half pack of cigarettes per day.

II. Medical Evidence[3]

A. Chest X-rays[4]

There are ten readings of four X-rays, taken on September 17, 2002, August 6, 2003, February 2, 2004 and May 4, 2004. (DX 15, 17; CX 1, 2; and EX 1, 2, 5 ,8 & 13). All of the readings are properly classified for pneumoconiosis, pursuant to 20 C.F.R. § 718.102(b).[5] Three are positive, by three physicians, Drs. Ranavaya, Aycoth and Cappiello, who are B-readers.[6] Four are negative, by three physicians, Drs. Wheeler, Scott, and Zaldivar, all of whom are either B-readers, Board-certified in radiology, or both.[7] One is contained in the claimant's records from a hospital admission at Logan Regional Hospital. This interpretation makes no mention of pneumoconiosis and is therefore, considered a negative reading.

Exh. #	Dates: 1. X-ray 2. read	Reading Physician	Qualifications	Film Quality	ILO Classification	Interpretation Or Impression
DX 15	9/17/02 9/17/02	Ranavaya	B	1	1/0; p/q	Other abnormalities noted: calcific densities of up to 1 cm in diameter noted in both upper lung regions and right hilar region which likely relates to healed granulomas but further

[3] *Dempsey v. Sewell Coal Co. & Director, OWCP*, ___ B.L.R. ___, BRB Nos. 03-0615 BLA and 03-0615 BLA-A (June 28, 2004). BRB upheld regulatory limitations on the admissibility of medical evidence, under the new 2001 regulations, i.e., 20 C.F.R. Sections 725.414 and 725.456(b)(1).

[4] In the absence of evidence to the contrary, compliance with the requirements of Appendix A shall be presumed. 20 C.F.R. § 718.102(e)(effective Jan. 19, 2001).

[5] ILO-UICC/Cincinnati classification of Pneumoconiosis – The most widely used system for the classification and interpretation of X-rays for the disease pneumoconiosis. This classification scheme was originally devised by the International Labor Organization (ILO) in 1958 and refined by the International Union Against Cancer (UICQ) in 1964. The scheme identifies six categories of pneumoconiosis based on type, profusion, and extent of opacities in the lungs.

[6] *LaBelle Processing Co. v. Swarrow,* 72 F.3d 308 (3rd Cir. 1995) at 310, n. 3. "A "B-reader" is a physician, often a radiologist, who has demonstrated proficiency in reading X-rays for pneumoconiosis by passing annually an examination established by the National Institute of Safety and Health and administered by the U.S. Department of Health and Human Services. *See* 20 C.F.R. § 718.202(a)(1)(ii)(E); 42 C.F.R. § 37.51. Courts generally give greater weight to X-ray readings performed by "B-readers." *See Mullins Coal Co. v. Director, OWCP*, 484 U.S. 135, 145 n. 16, 108 S.Ct. 427, 433 n. 16, 98 L.Ed. 2d 450 (1987); *Old Ben Coal Co. v. Battram*, 7 f.3d 1273, 1276 n. 2 (7th Cir. 1993)."

[7] *Cranor v. Peabody Coal Co.,* 21 B.L.R.1-201, BRB No. 97-1668 (Oct. 29, 1999) *on recon*. 22 B.L.R. 1-1 (Oct. 29, 1999)(*En banc*). Judge did not err considering a physician's X-ray interpretation "as positive for the existence of pneumoconiosis pursuant to Section 718.202(a)(1) without considering the doctor's comment." The doctor reported the category I pneumoconiosis found on X-ray was not CWP. The Board finds this comment "merely addresses the source of the diagnosed pneumoconiosis (& must be addressed under 20 C.F.R. § 718.203, causation)."

Exh. #	Dates: 1. X-ray 2. read	Reading Physician	Qualifications	Film Quality	ILO Classification	Interpretation Or Impression
						studies/investigations including CT scan, clinically correlation and follow up is recommended to rule out any other progressive pathology
DX 17	9/17/02 12/23/02	Burns	Qualifications not recorded	1	Not recorded	Reading for quality only. Noted at least two nodules, possibly granulomata
EX1	9/17/02 10/2/03	Wheeler	BCR, B	2	Negative	Moderate emphysema with increased AP diameter chest, moderate increased AP diameter chest and moderate bullous emphysema anterior rul. Check PFTS. Moderate obesity. Few small calcified granulomata upper lobes and right apex compatible with healed TB or possible healed histoplasmosis; Approximate CTR: 15/37.5 excluding epicardial fat. Check body mass index/obesity is a risk factor for serious diseases and the main cause of type 2 diabetes mellitus whose incidence rises sharply for BMI>27. Light PA/good quality lateral. No silicosis or CWP.
EX 5	8/6/03 8/26/03	Zaldivar	BCP,B	1	Negative	Partial atelectasis of lower zones due to the large bullae. Nodule in right mid zone and left upper zone may be CA.
EX 2	8/6/03	Wheeler	BCR,B	2	Negative	Chest PA –

Exh. #	Dates: 1. X-ray 2. read	Reading Physician	Qualifications	Film Quality	ILO Classification	Interpretation Or Impression
	9/12/03					emphysema with bullous bleb RUL and decreased markings LUL. Check PFTs. Probably obesity. Calcified granuloma lower RUL or superior segment RLL and tiny calcified granuloma lateral LUL compatible with healed TB or histoplasmosis. Probably no other abnormality but underexposure hides some lower lung detail. Repeat with good lower lung technique and lateral or get high resolution CT scan if clinically indicated. CTR: 15.5/38. Check body mass index/obesity is a risk factor for serious diseases and the main cause of Type 2 diabetes mellitus whose incidence rises sharply for BMI>27.
CX 1	2/2/04 2/5/04	Aycoth	B	1	1/2 ; p/q	There is a 1 cm. right upper lobe nodule and 5 mm. left upper lobe nodule. Otherwise, the heart, medicastinum, bony thorax, costophrenic angles and hemidiphragms are within normal limits. There are scattered rounded density opacities measuring up to 3 mm. in diameter throughout both lungs. The lungs are well aerated and free of

Exh. #	Dates: 1. X-ray 2. read	Reading Physician	Qualifications	Film Quality	ILO Classification	Interpretation Or Impression
						active disease. Suspect right upper lobe nodule neoplasm and left upper lobe granuloma.
CX 2	2/2/04 2/9/04	Cappiello	B	2	2/1; p/q	The cardiac silhouette is not enlarged. Pulmonary vasculature is normal. There is no evidence of infiltrate. There is hyperinflation of the lungs with changes of underlying chronic obstructive pulmonary disease. There are emphysematous bullae of medium size in the right upper lobe. There is a 5 mm. calcified granuloma in the left upper lobe and a 1 cm. calcified granuloma in the right mid lung zone. There are many small predominately rounded but some irregular parenchymal opacities throughout both lungs varying in size from a fraction of a millimeter up to approximately 1.5 mm. in diameter. There are no large opacities identified. There is no evidence of pleural plaque or pleural thickening.
EX 8	2/2/04 4/23/04	Wheeler	BCR, B	2	Negative	Chest PA [+ PA with incomplete left lateral chest: moderate emphysema with bullous bleb in most of the RUL

Exh. #	Dates: 1. X-ray 2. read	Reading Physician	Qualifications	Film Quality	ILO Classification	Interpretation Or Impression
						displacing minor fissure downward and possible bullous bleb in LUL. Check PFTs. Probably crowded lower lung markings accentuated by underexposure and overlying breasts but I can't exclude infiltrates or ill defined fibrosis. Get lateral view or high resolution CT scan for better evaluation. 1 cm. calcified granuloma upper mid portion right lung and 6 mm. calcified granuloma LUL compatible with healed TB or histoplasmosis. Tiny linear discoid atelectasis or scar above left lateral CPA. Probable obesity. Check body mass index/obesity risks serious diseases. Approximate CTR: 11/38.
EX 8	2/2/04 4/23/04	Scott	BCR,B	2	Negative	Bullous emphysema R>L upper lung. 1 cm calcified granuloma near right hilar and 5 mm calcified granuloma left upper lung.
EX 13	5/4/04 5/4/04	Cabauatan	Not in record	Not in record	Negative	Previous films available for comparison. Chronic changes noted with hyperaeration. Left upper lobe density and also right upper lobe density noted and these may be granulomatous

Exh. #	Dates: 1. X-ray 2. read	Reading Physician	Qualifications	Film Quality	ILO Classification	Interpretation Or Impression
						densities, however, correlation with the previous chest film suggested. No pleural effusion noted. Cardiac size is within normal limits. Degenerative changes of thoracic spine noted. Impression: Chronic changes with hyperaeration. Bilateral upper lobe densities as noted above. Normal sized heart. Suggest correlation with the previous chest film for further evaluation.

* A-A-reader; B-B-Reader; BCR – Board Certified Radiologist; BCP – Board-certified pulmonologist; BCI – Board-certified internal medicine; BCI(P) – Board-certified internal medicine with pulmonary medicine sub-specialty. Readers who are Board-certified radiologists and/or B-readers are classified as the most qualified. *See Mullins Coal Co. v. Director, OWCP,* 484 U.S. 135, 145 n. 16, 108 S.Ct. 427, 433 n. 16, 98 L.Ed. 2d 450 (1987) and, *Old Ben Coal Co. v. Battram,* 7 F.3d 1273, 1276 n. 2 (7th Cir. 1993). B-readers need not be radiologists.

**The existence of pneumoconiosis may be established by chest X-rays classified as category 1, 2, 3, A, B, or C according to ILO-U/C International Classification of Radiographs. A chest X-ray classified as category "0," including subcategories "0/-, 0/0, 0/1," does not constitute evidence of pneumoconiosis. 20 C.F.R. § 718.102(b). In some instances, it is proper for the judge to infer a negative interpretation where the reading does not mention the presence of pneumoconiosis. *Yeager v. Bethlehem Mines Corp*., 6 B.L.R. 1-307 (1983) (Under Part 727 of the Regulations) and *Billings v. Harlan #4 Coal Co.*, BRB No. 94-3721 (June 19, 1997)(*en banc)(Unpublished)*. If no categories are chosen, in box 2B(c) of the X-ray form, then the x-ray report is not classified according to the standards adopted by the regulations and cannot, therefore, support a finding of pneumoconiosis.

B. Pulmonary Function Studies[8]

Pulmonary Function Studies ("PFS") are tests performed to measure the degree of impairment of pulmonary function. They range from simple tests of ventilation to very sophisticated examinations requiring complicated equipment. The most frequently performed

[8] § 718.103(a)(Effective for tests conducted after Jan. 19, 2001 (See 718.101(b)), provides: "Any report of pulmonary function tests submitted in connection with a claim for benefits shall record the results of flow versus volume (flow-volume loop)." 65 Fed. Reg. 80047 (Dec. 20, 2000). In the case of a deceased miner, where no pulmonary function test are in substantial compliance with paragraphs (a) and (b) and Appendix B, noncomplying tests may form the basis for a finding if, in the opinion of the adjudication officer, the tests demonstrate technically valid results obtained with good cooperation of the miner. 20 C.F.R. § 718.103(c).

tests measure forced vital capacity (FVC), forced expiratory volume in one-second (FEV_1) and maximum voluntary ventilation (MVV).

Physician **Date** **Exh.#**	**Age** **Height**	**FEV_1**	**MVV**	**FVC**	**Tracings**	**Comprehension** **Cooperation**	**Qualify *** **Conform ****	**Dr.'s** **Impression**
Ranavaya 9/17/02 DX 12[9]	52 72	1.07 1.25*	Not in record	2.45 2.80*	Yes	Good Good	Yes Yes	Severe obstructive ventilatory defect due probably to emphysema with air trapping
Zaldivar 8/6/03 EX 3	53 72	1.17 1.21*	Not in record	4.41 4.70*	Yes	Not in record	Yes Yes	Severe irreversible airway obstruction; large lung volume with air trapping (remainder of comments cut off of copy submitted as evidence)
Crisalli 3/1/04 EX 6	54 72	1.02 1.68*	43 not in record	2.68 4.50*	Yes	Good Good	Yes Yes	Severe expiratory airflow obstruction; no restrictive defect; severe air trapping; mild diffusion defect; significant post-bronchodilator improvement

[9] This study was found to be acceptable by Dr. Gaziano. (DX 14). Dr. Gaziano is Board Certified in Internal Medicine and Chest Disease. (DX 14).

* Results, if any, after the administration of bronchodilators.

A "qualifying**" pulmonary study or arterial blood gas study yields values which are equal to or less than the applicable table values set forth in Appendices B and C of Part 718.

*** A study "**conforms**" if it complies with applicable standards (found in 20 C.F.R. § 718.103(b) and (c)). (*See Old Ben Coal Co. v. Battram*, 7 F.3d 1273, 1276 (7th Cir. 1993)). A judge may infer in the absence of evidence to the contrary, that the results reported represent the best of three trials. *Braden v. Director, OWCP,* 6 B.L.R. 1-1083 (1984). A study which is not accompanied by three tracings may be discredited. *Estes v. Director, OWCP*, 7 B.L.R. 1-414 (1984).

For a miner of the claimant's height of 72 inches, § 718.204(b)(2)(i) requires an FEV_1 equal to or less than 2.35 for a male 52 years of age, 2.33 for a male of 53 years of age and 2.31 for a male of 54 years of age. If such an FEV_1 is shown, there must be in addition, an FVC equal to or less than 2.96, 2.94 or 2.92, respectively or an MVV equal to or less than 94 or 93, respectively; or a ratio equal to or less than 55% when the results of the FEV_1 tests are divided by the results of the FVC test. Qualifying values for other ages and heights are as depicted in the table below. The FEV_1/FVC ratio requirement remains constant.

Height	**Age**	**FEV_1**	**FVC**	**MVV**
72 inches	52	2.35	2.96	94
72 inches	53	2.33	2.94	93
72 inches	54	2.31	2.92	93

C. Arterial Blood Gas Studies[10]

Blood gas studies are performed to detect an impairment in the process of alveolar gas exchange. This defect will manifest itself primarily as a fall in arterial oxygen tension either at rest or during exercise. A lower level of oxygen (O2) compared to carbon dioxide (CO2) in the blood, expressed in percentages, indicates a deficiency in the transfer of gases through the alveoli which will leave the miner disabled.

[10] 20 C.F.R. § 718.105 sets the quality standards for blood gas studies.
20 C.F.R. §718.204(b)(2) permits the use of such studies to establish "total disability." It provides: In the absence of contrary probative evidence which meets the standards of either paragraphs (b)(2)(i), (ii), (iii), or (iv) of this section shall establish a miner's total disability:…
(2)(ii) Arterial blood gas tests show the values listed in Appendix C to this part…

Date Ex. #	Physician	PCO2	PO2	Qualify	Physician Impression
9/17/02 DX 11	Ranavaya	40 38.7*	71 79.1*	No No	No additional comments noted
8/6/03 EX 3	Zaldivar	44 38*	58 69*	Yes No	Severe exercise limitation due to severe ventilatory and perfusion mismatch and severe ventilatory limitation
3/1/04 EX 6	Crisalli	45	66	No	No additional comments noted

*Results, if any, after exercise. Exercise studies are not required if medically contraindicated. 20 C.F.R. § 718.105(b).

Appendix C to Part 718 (Effective Jan. 19, 2001) states: "Tests shall not be performed during or soon after an acute respirator or cardiac illness."

D. Physicians' Reports[11]

A determination of the existence of pneumoconiosis may be made if a physician, exercising sound medical judgment, notwithstanding a negative X-ray, finds that the miner suffers or suffered from pneumoconiosis. 20 C.F.R. § 718.202(A)(4). Where total disability cannot be established, under 20 C.F.R. § 718.204(b)(2)(i) through (iii), or where pulmonary function tests and/or blood gas studies are medically contraindicated, total disability may be nevertheless found, if a physician, exercising reasoned medical judgment, based on medically acceptable clinical and laboratory diagnostic techniques, concludes that a miner's respiratory or pulmonary condition prevents or prevented the miner from engaging in employment, i.e., performing his usual coal mine work or comparable and gainful work. § 718.204(b).

Dr. Mohammed Ranavaya, a B-reader whose qualifications are not in the record, examined the claimant in connection with his claim for benefits. His examination report, based upon his examination of the claimant, on September 17, 2002, notes 17 years of coal mine employment and a 35-year smoking history. (DX 10). Dr. Ranavaya described the claimant's symptoms as daily production of gray, thick sputum, daily wheezing, daily dyspnea at rest worsening with exertion, two pillow orthopnea, occasional ankle edema and occasional paroxysmal nocturnal dyspnea.

[11] *Dempsey v. Sewell Coal Co. & Director, OWCP*, ___ B.L.R. ___, BRB Nos. 03-0615 BLA and 03-0615 BLA-A (June 28, 2004). Under (new) 2001 regulations, expert opinions must be based on admissible evidence.

Based on the claimant's occupational history, arterial blood gases, a pulmonary function study, and a positive chest X-ray, Dr. Ranavaya diagnosed the claimant as suffering from pneumoconiosis and chronic obstructive pulmonary disease.

He opined that the claimant's pulmonary conditions are related to his coal dust exposure and cigarette consumption.

Dr. George L. Zaldivar, is a B-reader and is Board-certified in internal medicine with subspecialties in pulmonary disease and sleep disorders. His examination report, based upon his examination of the claimant, on August 27, 2003, notes 17 years of coal mine employment and a 36-year smoking history. (EX 3). Dr. Zaldivar described the claimant's symptoms as shortness of breath, occasional swelling of the ankles and feet, wheezing and a chronic dry cough.

Based on arterial blood gases, a pulmonary function study, and a chest X-ray, Dr. Zaldivar diagnosed emphysema and asthma.

He opined that the claimant's pulmonary condition was not related to his coal dust exposure, but was related to his cigarette consumption.

Dr. Robert Crisalli, is a B-reader and is Board-certified in internal medicine with a subspecialty in pulmonary disease. His examination report based upon his examination of the claimant, on May 6, 2004, notes 18.25 years of coal mine employment and a 30-year smoking history. (EX 7). Dr. Crisalli described the claimant's symptoms as shortness of breath, daily cough with sputum production, two pillow orthopnea and occasional paroxysmal nocturnal dyspnea.

Based on arterial blood gases, a pulmonary function study, and a chest X-ray, Dr. Crisalli diagnosed emphysema, asthma, obesity, diabetes mellitus and hypertension.

He opined that the claimant's pulmonary condition was not related to his coal dust exposure, but was related to his cigarette consumption.

III. Hospital Records & Physician Office Notes

The claimant's medical records from a stay at Logan Regional Medical Center from May 4, 2004 to May 6, 2004 are included in the record in this matter. (EX 13). The claimant was admitted to the hospital for treatment of pneumococcal pneumonia. The claimant was admitted with the chief complaint of shortness of breath with a cough productive of yellow/brown sputum as well as a fever. The claimant was treated for his condition and released from the hospital after a two day stay.

IV. Witness' Testimony

The claimant testified at the time of the hearing in this matter. At that time, the claimant stated that he last worked in the coal mining industry for Arch Coal Company at Rutherford Mines driving a rock truck. (TR 9). The claimant further stated that he worked from 1974 to 1985 at Amhearst Mine Number Eight on the "move crew." (TR 10). As a part of his last job in the coal mine, the claimant had to "pre-shift the truck" which entailed walking "around the tires

and [climbing] up on the engine." (TR 11). The claimant further stated that he was required to maintain the truck to ensure its proper operation during his work shift.

The claimant last worked in 2001. (TR 12). He was awarded a twenty percent award for occupational disability from the West Virginia Occupational Pneumoconiosis Board in the 1980s. (TR 13). On cross-examination, the claimant explained his cigarette smoking history. (TR 13). This history included beginning to smoke in 1967 or 1968 and continuing to smoke "occasionally" at the time of the hearing. (TR 13). The claimant's medical history includes treatment for diabetes and high blood pressure. (TR 14). He is further limited in his mobility requiring the use of a scooter. (TR 16-17).

Dr. Crisalli was deposed on October 18, 2004 regarding his examination of the claimant. (EX 15). Dr. Crisalli reviewed his credentials as well as the history, physical and conclusions outlined in his written report of this examination. (EX 15, pp. 5-12). When discussing the claimant's medications, Dr. Crisalli indicated that none of the treatments currently being used are used to treat pneumoconiosis. (EX 15, p. 9). Dr. Crisalli went on to state that his findings at the claimant's examination are specific for emphysema. (EX 15, p. 12).

The claimant's PFS at the time of Dr. Crisalli's examination showed severe air trapping. (EX 15, p. 19). The results of this testing showed significant response to bronchodilation which is consistent with a diagnosis of asthma. (EX 15, p. 20). Dr. Crisalli further stated that the claimant's residual volume results further support a diagnosis of emphysema. (EX 15, p. 20).

In addressing the claimant's emphysema, Dr. Crisalli stated that the type of emphysema suffered by the claimant is not a result of coal dust exposure. (EX 15, p. 29). Dr. Crisalli opined that pneumoconiosis can cause obstructive ventilatory impairments, but that reversibility is not seen with obstructive impairments that arise out of exposure to coal dust. (EX 15, p. 30). Dr. Crisalli concluded that the claimant's PFS leads to a diagnosis of bullous emphysema, air trapping and asthma, none of which are related to the claimant's coal mine employment or coal dust exposure. (EX 15, p. 30).

Dr. Crisalli went on to discuss the claimant's arterial blood gas testing. Dr. Crisalli stated that the claimant's testing revealed resting hypoxemia of sufficient degree to induce a totally disabling respiratory impairment. (EX 15, p. 31). Dr. Crisalli concluded, after reviewing the claimant's medical records, that nothing in the claimant's medical history indicates coal dust exposure played a role in the claimant's asthma nor that exposure to coal dust in any way affected the claimant's lungs. (EX 15, pp. 36-37). Dr. Crisalli further concluded that the claimant's impairment is related entirely to claimant's smoking history. (EX 15, p. 40). However, Dr. Crisalli does believe that the claimant's problem is primarily related to his smoking history as evidenced by the existence of bullous emphysema with "obvious contribution from asthma." (Ex 15, p. 40).

Dr. Zaldivar was also deposed in connection with this matter. Dr. Zaldivar's deposition, taken on October 19, 2004, began with an explanation of Dr. Zaldivar's credentials and medical practice. (EX 16, pp.4-7). Dr. Zaldivar reviewed the history taken from the claimant as well as the claimant's complaints at the time of the examination. (EX 16, pp. 8-10). Dr. Zaldivar found no radiographic evidence of pneumoconiosis, but did find evidence of bullae and a single nodule

in the right mid-zone and left upper zone. (EX 16, pp. 13-14). He explained that the nodule noted concerned him for the presence of cancer, but did not look like coal workers' pneumoconiosis. (EX 16, pp. 14-15).

Coal workers' pneumoconiosis was ruled out by Dr. Zaldivar based on the chest x-ray as well as the fact that the claimant had not retained a lot of dust in his lungs. (EX 16, p. 15). He went on to explain the difference between his PFS testing when compared to those of Drs. Crisalli and Ranavaya. (EX 16, pp. 18-20). Dr. Zaldivar stated that while his PFS did not show reversibility, those of Drs. Crisalli and Ranavaya did exhibit reversibility. (EX 16, p. 19). Dr. Zaldivar attributes the variation in the results to the fact that the claimant suffers from bronchospasm. (EX 16, p. 19).

Dr. Zaldivar went on to discuss the fact that such variability in PFS and ABG results is not seen with coal workers' pneumoconiosis because it is a permanent and fixed impairment. (EX 16, p. 27). Dr. Zaldivar concluded that he did not believe that sufficient evidence existed to justify a diagnosis of coal workers' pneumoconiosis. This conclusion is based on the claimant's extensive smoking history and the presence of bullae. (EX 16, pp. 31-32). Additionally, Dr. Zaldivar stated that bronchospasm is not seen with coal workers' pneumoconiosis. (EX 16, p. 31). Dr. Zaldivar's impression of the claimant's condition is that the claimant suffers from a combination of bronchospasm due to "an asthmatic component to airway obstruction and a great deal of destruction of lung tissue from smoking." (EX 16, p. 32). When considering both the medical and legal definitions of coal workers' pneumoconiosis, Dr. Zaldivar reiterates that the claimant does not suffer from this condition. (EX 16, p. 36).

FINDINGS OF FACT AND CONCLUSIONS OF LAW

A. Entitlement to Benefits

This claim must be adjudicated under the regulations at 20 C.F.R. Part 718 because it was filed after March 31, 1980. Under this Part, the claimant must establish, by a preponderance of the evidence, that: (1) he has pneumoconiosis; (2) his pneumoconiosis arose out of coal mine employment; and, (3) he is totally disabled due to pneumoconiosis. Failure to establish any one of these elements precludes entitlement to benefits. 20 C.F.R. §§ 718.202-718.205; *Anderson v. Valley Camp of Utah, Inc.*, 12 B.L.R. 1-111, 1-112 (1989); *Trent v. Director, OWCP*, 11 B.L.R. 1-26 (1987); and, *Perry v. Director, OWCP*, 9 B.L.R. 1-1 (1986). *See Lane v. Union Carbide Corp.*, 105 F.3d 166, 170 (4th Cir. 1997). The claimant bears the burden of proving each element of the claim by a preponderance of the evidence, except insofar as a presumption may apply. *See Director, OWCP v. Mangifest*, 826 F.2d 1318, 1320 (3rd Cr. 1987). Failure to establish any of these elements precludes entitlement. *Perry v. Director, OWCP,* 9 B.L.R. 1-1 (1986). Moreover, "[T]he presence of evidence favorable to the claimant or even a tie in the proof will not suffice to meet that burden." *Eastover Mining Co. v. Director, OWCP [Williams]*, ___ F.3d ___, No. 01-4064 (6th Cir. July 31, 2003), *citing Greenwhich Collieries [Ondecko]*, 512 U.S. 267 at 281.

B. Existence of Pneumoconiosis

Pneumoconiosis is defined as a "chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment." 30 U.S.C. § 902(b) and 20 C.F.R. § 718.201. The definition is not confined to "coal workers' pneumoconiosis," but also includes other diseases arising out of coal mine employment, such as anthracosilisosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, progressive massive fibrosis, silicosis, or silicotuberculosis. 20 C.F.R. § 718.201.[12]

The term "arising out of coal mine employment" is defined as including "any chronic pulmonary disease resulting in respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment." Thus, "pneumoconiosis", as defined by the Act, has a much broader legal meaning than does the medical definition.

"…[T]his broad definition 'effectively allows for the compensation of miners suffering from a variety of respiratory problems that may bear a relationship to their employment in the coal mines.'" *Robinson v. Pickands Mather & Co./Leslie Coal Co. & Director, OWCP*, 14 B.L.R. 2-68 (4th Cir. 1990) at 2-78, 914 F.2d 35 (4th Cir. 1990) *citing, Rose v. Clinchfield Coal Co.*, 614 F.2d 936, 938 (4th Cir. 1980).

Thus, asthma, asthmatic bronchitis, or emphysema may fall under the regulatory definition of pneumoconiosis if they are related to coal dust exposure. *Robinson v. Director, OWCP*, 3 B.L.R. 1-798.7 (1981); *Tokarcik v. Consolidation Coal Co.*, 6 B.L.R. 1-666 (1983). Likewise, chronic obstructive pulmonary disease may be encompassed within the legal definition of pneumoconiosis. *Warth v. Southern Ohio Coal Co.*, 60 F.3d 173 (4th Cir. 1995) and *see* § 718.201(a)(2).

The claimant has the burden of proving the existence of pneumoconiosis. The Regulations provide the means of establishing the existence of pneumoconiosis by: (1) a chest X-ray meeting the criteria set forth in 20 C.F.R. § 718.202(a)(1); (2) a biopsy or autopsy conducted

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[12] Regulatory amendments, effective January 19, 2001, state:

(a) For the purpose of the Act, "pneumoconiosis" means a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. This definition includes both medical, or "clinical", pneumoconiosis and statutory, or "legal", pneumoconiosis.

(1) Clinical Pneumoconiosis. "Clinical pneumoconiosis" consists of those diseases recognized by the medical community as pneumoconiosis, i.e., the conditions characterized by permanent deposition of substantial amounts of particulate matter in the lungs and the fibrotic reaction of the lung tissue to that deposition caused by dust exposure in coal mine employment. This definition includes, but is not limited to, coal workers' pneumoconiosis, anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, silicosis or silicotuberculosis, arising out of coal mine employment.

(2) Legal Pneumoconiosis. "Legal pneumoconiosis" includes any chronic lung disease or impairment and its sequelae arising out of coal mine employment. This definition includes, but is not limited to, any chronic restrictive or obstructive pulmonary disease arising out of coal mine employment.

(b) For purposes of this section, a disease "arising out of coal mine employment" includes any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment.

(c) For purposes of this definition, "pneumoconiosis" is recognized as a latent and progressive disease which may first become detectable only after the cessation of coal mine dust exposure.
(Emphasis added).

and reported in compliance with 20 C.F.R. § 718.106; (3) application of the irrebuttable presumption for "complicated pneumoconiosis" found in 20 C.F.R. § 718.304; or (4) a determination of the existence of pneumoconiosis made by a physician exercising sound judgment, based upon certain clinical data and medical and work histories, and supported by a reasoned medical opinion.[13] 20 C.F.R. § 718.202(a)(4).

In *Island Creek Coal Co. v. Compton*, 211 F.3d 203, 2000 WL 524798 (4th Cir. 2000), the Fourth Circuit held that the administrative law judge must weigh all evidence together under 20 C.F.R. § 718.202(a) to determine whether the miner suffered from coal workers' pneumoconiosis. This is contrary to the Board's view that an administrative law judge may weigh the evidence under each subsection separately, i.e. X-ray evidence at § 718.202(a)(1) is weighed apart from the medical opinion evidence at § 718.202(a)(4). In so holding, the court cited to the Third Circuit's decision in *Penn Allegheny Coal co. v. Williams,* 114 F.3d 22, 24-25 (3d Cir. 1997) which requires the same analysis.

The claimant cannot establish pneumoconiosis pursuant to subsection 718.202(a)(2) because there is no biopsy evidence in the record. The claimant cannot establish pneumoconiosis under § 718.202(a)(3), as none of that sections presumptions are applicable to a living miner's claim field after January 1, 1982, with no evidence of complicated pneumoconiosis.

A finding of the existence of pneumoconiosis may be made with positive chest X-ray evidence. 20 C.F.R. § 718.202(a)(1). The correlation between "physiologic and radiographic abnormalities is poor" in cases involving CWP. "[W]here two or more X-ray reports are in conflict, in evaluating such X-ray reports, consideration shall be given to the radiological qualifications of the physicians interpreting such X-rays." *Id.; Dixon v. North Camp Coal Co*., 8 B.L.R. 1-344 (1985)." (Emphasis added). (Fact one is Board-certified in internal medicine or highly published is not so equated). *Melnick v. Consolidation Coal Co. & Director, OWCP*, 16 B.L.R. 1-31 (1991) at 1-37. Readers who are Board-certified radiologists and/or B-readers are classified as the most qualified. The qualifications of a certified radiologist are at least comparable to if not superior to a physician certified as a B-reader. *Roberts v. Bethlehem Mines Corp.*, 8 B.L.R. 1-211, 1-213 n.5 (1985).

A judge is not required to defer to the numerical superiority of X-ray evidence, although it is within his or her discretion to do so. *Wilt v. Wolverine Mining Co.*, 14 B.L.R. 1-70 (1990) citing *Edmiston v. F & R Coal*, 14 B.L.R. 1-65 (1990). This is particularly so where the majority of negative readings are by the most qualified physicians. *Dixon v. North Camp Coal Co.*, 8 B.L.R. 1-344(1985); *Melnick v. Consolidation Coal Co. & Director, OWCP,* 16 B.L.R. 1-31, 1-37 (1991).

[13] In accordance with the Board's guidance, I find each medical opinion documented and reasoned, unless otherwise noted. *Collins v. J & L Steel,* 21 B.L.R. 1-182 (1999) *citing Trumbo v. Reading Anthracite Co.*, 17 B.L.R. 1-85 (1993); *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19 (1987); and, *Sterling Smokeless Coal Co. v. Akers*, 121 F.3d 438, 21 B.L.R. 2-269 (4th Cir. 1997). This is the case, because except as otherwise noted, they are "documented" (medical), i.e., the reports set forth the clinical findings, observations, facts, etc., on which the doctor has based his diagnosis and "reasoned" since the documentation supports the doctor's assessment of the miner's health.

I find that the claimant has failed to establish the existence of pneumoconiosis by a preponderance of the chest x-ray evidence. I attribute more weight to the interpretations of the dually qualified physicians of record, none of which found the existence of pneumoconiosis. Therefore, I find that the claimant has failed to establish the existence of pneumoconiosis by a preponderance of the chest x-ray evidence.

A determination of the existence of pneumoconiosis can be made if a physician, exercising sound medical judgment, based upon certain clinical data, medical and work histories and supported by a reasoned medical opinion, finds the miner suffers or suffered from pneumoconiosis, as defined in § 718.201, notwithstanding a negative X-ray. 20 C.F.R. § 718.202(a).

Medical reports which are based upon and supported by patient histories, a review of symptoms, and a physical examination constitute adequately documented medical pinions as contemplated by the Regulations. *Justice v. Director, OWCP*, 6 B.L.R. 1-1127 (1984). However, where the physician's report, although documented, fails to explain how the documentation supports its conclusions, an Administrative Law Judge may find the report is not a reasoned medical opinion. *Smith v. Eastern Coal Co.*, 6 B.L.R. 1-1130 (1984). A medical opinion shall not be considered sufficiently reasoned if the underlying objective medical data contradicts it.[14] *White v. Director, OWCP*, 6 B.L.R. 1-368 (1983).

Physician's qualifications are relevant in assessing the respective probative value to which their opinions are entitled. *Burns v. Director, OWCP*, 7 B.L.R. 1-597 (1984). Because of their various Board-certifications, B-reader status, and expertise, as noted above, I rank Drs. Zaldivar and Crisalli above that of Dr. Ranavaya.

As a general rule, more weight is given to the most recent evidence because pneumoconiosis is a progressive and irreversible disease. *Stanford v. Director, OWCP*, 7 B.L.R. 1-541 (1984); *Tokarcik v. Consolidated Coal Co.*, 6 B.L.R. 1-166 (1983); and, *Call v. Director, OWCP*, 2 B.L.R. 1-146 (1979).[15] This rule is not to be mechanically applied to require that later evidence be accepted over earlier evidence. *Burns v. Director, OWCP*, 7 B.L.R. 1-597 (1984).

Adkins v. Director, OWCP, 958 F.2d 49, 16 B.L.R. 2-61 (4th Cir. 1992). It is rational to credit more recent evidence, solely on the basis of recency, only if it shows the miner's condition has progressed or worsened. The court reasoned that, because it is impossible to reconcile

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[14] *Fields v. Director, OWCP*, 10 B.L.R. 1-19, 1-22 (1987). "A 'documented' (medical) report sets forth the clinical findings, observations, facts, etc., on which the doctor has based his diagnosis. A report is 'reasoned' if the documentation supports the doctor's assessment of the miner's health. *Fuller v. Gibraltor Coal Corp.*, 6 B.L.R. 1-1291 (1984)…"

[15] *Cranor v. Peabody Coal Co.*, 21 B.L.R. 1-201, BRB No. 97-1668 (Oct. 29, 1999) *on recon*. 22 B.L.R. 1-1 (Oct. 29, 1999)(*En Banc.*). In a case arising in the Sixth Circuit, the Board held it was proper for the judge to give greater weight to more recent evidence, as the Circuit has found CWP to be a "progressive and degenerative disease." *See also Abshire v. D & L Coal Co*. 22 B.L.R. 1-203 (2002), citing *Staton v. Norfolk & Western Railroad Co.*, 65 F.3d 55, 19 B.L.R. 2-271 (6th Cir. 1995); *Woodward v. Director, OWCP,* 991 F.2d 314, 17 B.L.R. 2-77 (6th Cir. 1993); *Edmiston v. F & R Coal Co.*, 14 B.L.R. 1-65 (1990); and, *Clark v. Karst-Robbin Coal Co*., 12 B.L.R. 10-149 (1989), the Board holds greater weight may be accorded to more recent X-ray evidence of record. In *Abshire*, the Board also recognized *Mullins Coal Co. of Virginia v. Director, OWCP*, 484 U.S. 135, 11 B.L.R. 2-1 (1987) (CWP is a progressive disease).

conflicting evidence based on its chronological order if the evidence shows that a miner's condition has improved, inasmuch as pneumoconiosis is a progressive disease and claimants cannot get better, "[e]ither the earlier or later result must be wrong, and it is just as likely that the later evidence is faulty as the earlier…" *See also, Thorn v. Itmann Coal Co.,* 3 F.3d 713, 18 B.L.R. 2-16 (4th Cir. 1993).

It is proper for an administrative law judge to accord greater weight to a physician who "integrated all of the objective evidence" more than contrary physicians of record, particularly where he considered tests results showing diffusion impairment, reversibility studies, and blood gas readings. *Midland Coal Co. v. Director, OWCP [Shores]*, 358 F.3d 486 (7th Cir. 2004).

A general disability determination by a state or other agency is not binding on the Department of Labor with regard to a claim field under Part C, but the determination may be used as some evidence of disability or rejected as irrelevant at the discretion of the fact-finder.[16] *Schegan v. Waste Management & Processors, Inc.*, 18 B.L.R. 1-41 (1994); *Miles v. Central Appalachian Coal Co.*, 7 B.L.R. 1-744 (1985); *Stanley v. Eastern Associated Coal Corp.*, 6 B.L.R. 1-1157 (1984) (opinion by the West Virginia Occupational Pneumoconiosis Board of a "15% pulmonary functional impairment" is relevant to disability but not binding). *McMath v. Director, OWCP,* 12 B.L.R. 1-6 (1988). Thus, I give the state determination some weight as to the existence of pneumoconiosis.

I find the claimant has not met his burden of proof in establishing the existence of pneumoconiosis. *Director, OWCP v. Greenwich Collieries*, 512 U.S. 267, 114 S.Ct. 2251, 129 L.Ed.2d 221 (1994) *aff'g sub. nom. Greenwich Collieries v. Director, OWCP,* 990 F.2d 730, 17 B.L.R. 2-64 (3d Cir. 1993).

Unlike Dr. Ranavaya, who merely completed a Department of Labor form, Drs. Crisalli and Zaldivar integrated all of the objective medical evidence of record in offering their opinions. Both physicians went to great lengths to explain the appearance of the claimant's chest x-rays as well as explaining the varying results of the PFS and ABG studies. I find that their opinion are entitled to greater weight because they incorporated all of the objective medical evidence and reduced it to an opinion that explained all of the claimant's results.

C. Cause of Pneumoconiosis

Once the miner is found to have pneumoconiosis, he must show that it arose, at least in part, out of coal mine employment. 20 C.F.R. § 718.203(a). If a miner who is suffering from pneumoconiosis was employed for ten years or more in the coal mines, there is a rebuttable presumption that the pneumoconiosis arose out of such employment. 20 C.F.R § 718.203(b). If a miner who is suffering or suffered from pneumoconiosis was employed less than ten years in the nation's coal mines, it shall be determined that such pneumoconiosis arose out of coal mine employment only if competent evidence establishes such a relationship. 20 C.F.R. § 718.203(c).

[16] See § 718.206 "Effect of findings by persons or agencies." (65 Fed. Reg. 80050, Dec. 20, 2000) (Effective Jan. 19, 2001). If properly submitted, such evidence shall be considered and given the weight to which it is entitled as evidence under all the facts before the adjudication officer in the claim.

Since the miner had ten years or more of coal mine employment, the claimant would ordinarily receive the benefit of the rebuttable presumption that his pneumoconiosis arose out of coal mine employment. However, in view of my finding that the existence of CWP has not been proven the issue is moot. Moreover, the presumption is rebutted by the medical opinion evidence discussed herein.

D. Existence of total disability due to pneumoconiosis

The claimant must show his total pulmonary disability is caused by pneumoconiosis. 20 C.F.R. § 718.204(b).[17] Section 718.204(b)(2)(i) through (b)(2)(iv) set forth criteria to establish total disability: (i) pulmonary function studies with qualifying values; (ii) blood gas studies with qualifying values; (iii) evidence that miner has pneumoconiosis and suffers from cor pulmonale with right-side congestive heart failure; (iv) reasoned medical opinions concluding the miner's respiratory or pulmonary condition prevents him from engaging in his usual coal mine employment; and lay testimony.[18] Under this subsection, the Administrative Law Judge must consider all the evidence of record and determine whether the record contains "contrary probative evidence." If it does, the Administrative Law Judge must assign this evidence appropriate weight and determine "whether it outweighs the evidence supportive of a finding of total respiratory disability." *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19, 1-21 (1987); *see also Shedlock v. Bethlehem Mines Corp.*, 9 B.L.R. 1-195, 1-198 (1986), *aff'd on reconsideration en banc*, 9 B.L.R. 1-236 (1987).

Section 718.204(b)(2)(iii) is not applicable because there is no evidence that the claimant suffers from cor pulmonale with right-sided congestive heart failure. § 718.204(d) is not applicable because it only applies to a survivor's claim or deceased miners' claim in the absence of medical or other relevant evidence.

Section 718.204(b)(2)(i) provides that a pulmonary function test may establish total disability if its values are equal to or less than those listed in Appendix B of Part 718. More weight may be accorded to the results of a recent ventilatory study over those of an earlier study. *Coleman v. Ramey Coal Co.,* 18 B.L.R. 1-9 (1993). All of the pulmonary function tests met Department of Labor total disability standards.

Claimants may also demonstrate total disability due to pneumoconiosis based on the results of arterial blood gas studies that evidence an impairment in the transfer of oxygen and carbon dioxide between the lung alveoli and the blood stream. § 718.204(b)(2)(ii). More weight

[17] § 718.204 (Effective Jan. 19, 2001). Total disability and disability causation defined; criteria for determining total disability and total disability due to pneumoconiosis, states: (a) General. Benefits are provided under the Act for or on behalf of miners who are totally disabled due to pneumoconiosis, or who were totally disabled due to pneumoconiosis at the time of death. Fro purposes of this section, any nonpulmonary or nonrespiratory condition or disease, which causes an independent disability unrelated to the miner's pulmonary or respiratory disability, shall not be considered in determining whether a miner is totally disabled due to pneumoconiosis. If, however, a nonpulmonary or nonrespiratory condition or disease shall be considered in determining whether a miner is or was totally disabled due to pneumoconiosis.

[18] In a living miner's claim, lay testimony "is not sufficient, in and of itself, to establish disability." *Tedesco v. Director, OWCP*, 18 B.L.R. 1-103 (1994). See 20 C.F.R. § 718.204(d)(5)(living miner's statements or testimony insufficient alone to establish total disability).

may be accorded to the results of a recent blood gas study over one which was conducted earlier. *Schretroma v. Director, OWCP*, 18 B.L.R. 1-17 (1993). The arterial blood gas studies are predominantly nonqualifying.

Finally, total disability may be demonstrated, under § 718.204(b)(2)(iv), if a physician, exercising reasoned medial judgment, based on medically acceptable clinical and laboratory diagnostic techniques, concludes that a miner's respiratory or pulmonary condition presents or prevented the miner from engaging in employment, i.e., performing his usual coal mine work or comparable or gainful work. § 718.204(b). Under this subsection, "…all the evidence relevant to the question of total disability due to pneumoconiosis is to be weighed, with the claimant bearing the burden of establishing, by a preponderance of the evidence, the existence of this element." *Mazgaj v. Valley Coal Company*, 9 B.L.R. 1-201 (1986) at 1-204. The fact finder must compare the exertional requirements of the claimant's usual coal mine employment with a physician's assessment of the claimant's respiratory impairment. *Schetroma v. Director, OWCP,* 18 B.L.R. 1-19 (1993). Once it is demonstrated that the miner is unable to perform his usual coal mine work a *prima facie* finding of total disability is made and the burden of going forward with evidence to prove the claimant is able to perform gainful and comparable work falls upon the party opposing entitlement, as defined pursuant to 20 C.F.R. § 718.204(b)(2). *Taylor v. Evans & Gambrel Co.*, 12 B.L.R. 1-83 (1988). Drs. Ranavaya, Zaldivar, and Crisalli all agree that the claimant has a total respiratory disability.

I find that the miner's last coal mining positions required hard manual labor. Because the claimant's symptoms render him unable to walk short distances and climb in to the cab of his truck, and in light of the medical opinions, I find he is incapable of performing his prior coal mine employment.

The Fourth Circuit rule is that "nonrespiratory and nonpulmonary impairments have no bearing on establishing total disability due to pneumoconiosis." *Jewell Smokeless Coal Corp. v. Street,* 42 F.3d 241 (4th Cir. 1994). In *Milburn Colliery Co. v. Director, OWCP, [Hicks]*, 21 B.L.R. 2-323, 138 F.3d 524, Case No. 96-2438 (4th Cir. Mar. 6, 1998) *citing Jewell Smokeless Coal Corp. v. Street*, 42 F.3d 241, 243 (4th Cir. 1994), the Court had "rejected the argument that '[a] miner need only establish that he has a total disability, which may be due to pneumoconiosis in combination with nonrespiratory and nonpulmonary impairments." Even if it is determined that claimant suffers from a totally disabling respiratory condition, he "will not be eligible for benefits if he would have been totally disabled to the same degree because of his other health problems." *Id.* at 534.

The Benefits Review Board has held that nonrespiratory and nonpulmonary impairments are irrelevant to establishing total disability, under 20 C.F.R. § 718.204. *Beatty v. Danri Corp.*, 16 B.L.R. 1-1 (1991).

I find the claimant has met his burden of proof in establishing the existence of total disability. *Director, OWCP v. Greenwich Collieries [Ondecko]*, 512 U.S. 267, 114 S.Ct. 2251, 129 L.Ed.2d 221 (1994), *aff'g sub. Nom. Greenwich Colleries v. Director, OWCP*, 990 F.2d 730, 17 B.L.R. 2-64 (3d Cir. 1993).

E. Cause of total disability

The revised regulations, 20 C.F.R. § 718.20(c)(1), require a claimant establish his pneumoconiosis is a "substantially contributing cause" of his totally disabling respiratory or pulmonary disability. The January 19, 2001 changes to 20 C.F.R. § 718.204(c)(1)(i) an d(ii), adding the words "material" and "materially", results in "evidence that pneumoconiosis makes only a negligible, inconsequential, or insignificant contribution to the miner's total disability is insufficient to establish that pneumoconiosis is a substantially contributing cause of that disability." 65 Fed. Reg. No. 245, 799946 (Dec. 20, 2000).

The Fourth Circuit Court of Appeals requires that pneumoconiosis be a "contributing cause" of the claimant's total disability. *Toler v. Eastern Associated Coal Co.*, 43 F.3d 109, 112 (4th Cir. 1995); *Jewel Smokeless Coal Corp. v. Street*, 42 F.3d 241, 243 (4th Cir. 1994). In *Street*, the Court emphasized the steps by which the cause of total disability may be determined by directing "the Administrative Law Judge [to] determine whether [the claimant] suffers from a respirator or pulmonary impairment that is totally disabling and whether [the claimant's] pneumoconiosis contributes to this disability." *Street*, 42 F.3d 241 at 245.

There is evidence of record that claimant's respiratory disability is due, in part, to his undisputed history of cigarette smoking.[19] However, to qualify for Black Lung benefits, the claimant need not prove that pneumoconiosis is the "sole" or "direct" cause of his respiratory disability, but rather that it has contributed to his disability. *Robinson v. Pickands Mather & Co./Leslie Coal Co. & Director, OWCP*, 914 F.2d 35, 14 B.L.R. 2-68 (4th Cir. 1990) at 2-76. *Jones v. Badger Coal Co.*, 21 B.L.R. 1-102, BRB No. 97-1393 BLA (Nov. 30, 1998)(*en banc*). There is no requirement that doctors "specifically apportion the effects of the miner's smoking and his dust exposure in coal mine employment upon the miner's condition." *Jones v. Badger Coal Co.*, 21 B.L.R. 1-102, BRB No. 97-1393 BLA (Nov. 30, 1998)(*en banc*) *citing generally, Gorzalka v. Big Horn Coal Co.*, 16 B.L.R. 1-48 (1990). The better-qualified physicians do not find an occupational lung disease.

If the claimant would have been disabled to the same degree and by the same time in his life had he never been a miner, then benefits cannot be awarded. *Hobbs v. Clinchfield Coal Co.*, 917 F.2d 790, 792 (4th Cir. 1990); *Robinson v. Picklands Mather & Co.*, 914 F.2d 35, 38 (4th Cir. 1990).

I find that the claimant has failed to establish that his coal workers' pneumoconiosis was a substantially contributing cause of his total respiratory disability. As I have found that the claimant has failed to establish the existence of pneumoconiosis, it would be impossible for him to establish that such condition substantially contributed to his total respiratory disability. Additionally, I find that the claimant's respiratory condition is a result of his extensive cigarette smoking history.

[19] *Sewell Coal Co. v. Director, OWCP [O'Dell]* (Unpublished), 22 B.L.R. 2-213, No. 00-2253 (4th Cir. July 26, 2001)(Unpublished). "…the mere documentation of a smoking history on the official OWCP form or elsewhere, without more, cannot reasonably imply that an examining physician has 'addressed the possibility that cigarette smoking caused the claimant's disability." *Malcomb v. Island Creek Coal Co.*, 15 F.3d 364 at 371 (4th Cir. 1994).

ATTORNEY FEES

The award of attorney's fees, under the Act, is permitted only in cases in which the claimant is found to be entitled to the receipt of benefits. Since benefits are not awarded in this case, the Act prohibits the charging of any fee to the claimant for the representation services rendered to him in pursuit of the claim.

CONCLUSIONS

In conclusion, the claimant does not have pneumoconiosis, as defined by the Act and Regulations, which arose out of coal mine employment. The claimant is totally disabled. However, his total disability was not due to pneumoconiosis. He is therefore not entitled to benefits.

ORDER[20]

It is ordered that the claim of Richard L. Owsley for benefits under the Black Lung Benefits Act is hereby DENIED.

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RICHARD A. MORGAN
Administrative Law Judge

NOTICE OF APPEAL RIGHTS (**Effective Jan. 19, 2001**): Pursuant to 20 C.F.R. § 725.481, any party dissatisfied with this Decision and Order may appeal it to the Benefits Review Board before the decision becomes final, i.e., at the expiration of thirty (30) days after "filing" (or **receipt by**) with the Division of Coal Mine Workers' Compensation, OWCP, ESA, ("DCMWC"), by filing a Notice of Appeal with the **Benefits Review Board, ATTN: Clerk of the Board, P.O. Box 37601, Washington, D.C. 20013-7601.**[21]

[20] § 725.478 Filing and service of decision and order (Change effective Jan. 19, 2001). Upon receipt of a decision and order by the DCMWC, the decision and order shall be considered to be filed in the office of the district director, and shall become effective on that date.

[21] 20 C.F.R. § 725.479 (Change effective Jan. 19, 2001). (d) Regardless of any defect in service, **actual receipt** of the decision is sufficient to commence the 30-day period for requesting reconsideration or appealing the decision.